

Ethical and Legal Considerations in the Relationship between Medical Scheme and Member

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DECLARATION

I, Howard Snoyman (student number: 388096) submit the following research report entitled "Ethical and Legal Considerations in the Relationship between Medical Scheme and Member".

I hereby declare the following:

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Dedication

This research report is dedicated to all persons employed in government, pharmaceutical companies and medical schemes as well as members of the public, who strive to procure the optimum balance of scheme profitability on the one hand, and scheme members' rights on the other.

Abstract

South African medical schemes (health insurance or medical aid) companies offer insurance to the general public in the form of a multitude of different schemes. Each scheme has its own unique range of benefits, but certain exclusions apply across the board in respect of all schemes operated by a medical aid. In this research report, I investigate the rationale and necessity, as well as some of the ethical and legal implications of numerous notable exclusions. I further make relevant recommendations with respect to their application within the legal and ethical framework of the South Africa's Consumer Protection Act, No. 68 of 2010.

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Nomenclature

“Medical schemes”, “health insurers” and “medical aids” in the South African context are terms used synonymously.

The terms **“patient”, “consumer”** and **“(scheme) member”** are sometimes used synonymously. By means of a brief explanation, in the context of a medical consultation, the person consulting with a physician is termed a patient, in the context of the Consumer Protection Act, that same person is termed a “consumer”, and in respect of the relationship between that person and the medical scheme to which they belong, that same person will be referred to as a “member” of such scheme.

“Normal health” shall mean the level of health of the average South African resident;

“Optimum health” shall mean peak or near peak levels of health in an ideal circumstance;

“restorative treatment” shall mean any treatment intended to restore the patient to the level of health that they had prior to the relevant disease / condition;

“professional sports people” shall in this context mean people that either earn their living from competing in sports, or compete at an elite level;

“Cost effective clinician” shall mean a doctor whose charges are viewed as reasonable in the context of the necessary treatment.

“Open medical scheme” means a plan in respect of which membership is discretionary, and members join of their own free volition.

“Closed scheme” means a scheme such as Bankmed, in respect of which employees do not have an option but to join such scheme. This is done for various reasons, whether ease of administration or the accumulation of group benefits according to critical mass. Closed schemes are not dealt with in this research report in significant depth because members do not have a choice to resign from the scheme and find a scheme which is more suitable; hence any discussion on the imperfections of such schemes would have little effect, as the scheme management knows that there is no danger of loss of membership.

Chapter 1:South Africa and Medical Schemes: A Brief Overview

1.1 South Africa and the medical schemes industry

South Africa has a two-tier health system with a large private health sector, funded primarily from individual and employer insurance contributions, out-of-pocket payment, and government tax subsidies and a public health sector almost fully funded by public taxes. The health sector accounts for 8.7% of the country's GDP – 3.5% of this expenditure is in the public sector (serving over 80% of the population) and the other 5.2% of expenditure is in the private sector (Mutiyambizi, 2007:2).

Private Mutual Health Insurers or Medical Schemes have existed in South Africa for over 100 years (Söderlund & Hansl 2000: 378). With the early economic boom during the 1800's (primarily due to developments in the mining industry) some levels of private funding for health care in South Africa can be traced back to as early as 1889(Pearmain, 2000:183). Concurrently, from the 1800's to at least the advent of Medical Scheme regulations in 1967, there was little emphasis placed on the public provision of health insurance. This of course, was mainly

due to the Apartheid system then in place. For the majority of the population, health care provision during this time was largely managed by international, local, religious and other non-governmental institutions who set up hospitals and clinics in the 'homelands' as well as other, mainly rural areas.

With the advent of a more formal development of industry, medical schemes grew in keeping with Western trends of the time viz. ingenious marketing strategies of the medical health industry which included the promulgation of the idea that employers should provide some type of basic health coverage for employees. In South Africa, medical schemes developed and largely prospered. One reason for this was that they were largely unregulated by the government.

In 1967, the promulgation of The Medical Schemes Act (Act 72 of 1967) set out to both recognise and regulate the medical schemes industry. As reported by Söderlund & Hansl (2000: 378) from 1969 until about the mid-1980's the government became a major voice in the management of medical schemes. For example, at that time differential premiums based on poor-health risk were considered illegal (van den Heever, 1998: 282).

As was the general trend in most other countries,, the bulk of health care insurance then, as now, is provided by an employer for the purpose of employee benefit and as a buffer against possible legal claims against the employer in the case of a catastrophic event. Such health insurance coverage is 'designed' as business or industry-specific, in what is referred to as a 'closed fund'(Söderlund et al. 1999). In other words, the medical scheme is tailored to suit employee healthcare needs which are pre-determined by the particular medical scheme that the employer chooses. As Pearmain (2000:184) notes, "... in 1960 there were 169 schemes covering 1.5 million persons". This proliferation of medical schemes, regulated to benefit the minority population was the general mode of operation until the mid 1960's.

In 1967, a Medical Schemes Act was passed in South Africa which was altered by numerous amendments. Despite these challenges the Act remained unaltered. (Söderlund & Hansl 2000: 378). Yet, in 1993 the most important amendment came about which would change the face of the industry, namely deregulation (Pearmain 2000: 184). At this time, small-group and individual medical scheme coverage became available; known as

'open funding' (ibid). Practically, one of the consequences of this was that medical schemes now were allowed detailed and individual-specific risk rating e.g. assessment of previous claims, medical history as well as an individual's current health status (Pearmain 2000: 185). Other effects were that benefits for the elderly were diminished or their premiums were raised in accordance with risk profiling. Generally, the industry's focus shifted as its structures and benefits were geared to attract the young and healthy.

With deregulation, medical schemes essentially were facilitated to be run as highly profitable businesses. Medical scheme brokers, administrators, managed care organisations and boards of directors are examples of the groups which played a part of the network of affiliations which added bulk and political weight to the medical schemes industry. Overall, it was reasoned that the deregulation would lead to greater industry growth, benefit the business sector, and provide a larger taxation base which would benefit the country's economic growth.

As medical schemes became economically viable as businesses, this contributed to the capitalist system. The government backed off, to at least a considerable extent,

it's hither-to control of the medical schemes industry allowing the ideas of e.g. for-profit as well as their perceptions of the rising costs of medicine to inform their actions (Söderlund & Hansl 2000: 379).

In 1998, new legislation came into place with the Medical Schemes Act, No. 131 of 1998. This Act introduced further changes, including: a compulsory minimum benefits package, applicable to all schemes; a prohibition on discrimination on the basis of age, medical history and health status; requiring that contributions / premiums be determined only on the basis of income and / or number of dependants; a prohibition on medical schemes excluding applicants for membership, or their dependants, except under certain prescribed conditions; and regulating administrators and other contractors to medical schemes, for example brokers and managed care organisations (Pearmain, 2000: 185 - 187).

Section 3 of the Medical Schemes Act, No. 131 of 1998, introduced for the first time the Council of Medical Schemes, whose function it is to:

protect the interests of the beneficiaries at all times; control and co-ordinate the functioning of medical schemes in a manner that is complementary with the

national health policy; make recommendations to the Minister on criteria for the measurement of quality and outcomes of the relevant health services provided for by medical schemes, and such other services as the Council may from time to time determine; investigate complaints and settle disputes in relation to the affairs of medical schemes as provided for in this Act; collect and disseminate information about private health care; make rules, not inconsistent with the provisions of this Act for the purpose of the performance of its functions and the exercise of its powers; advise the Minister on any matter concerning medical schemes; and perform any other functions conferred on the Council by the Minister or by this Act. (Medical Schemes Act, No 131, 1998)¹

The status quo within the Medical Aid industry is that different schemes provide several different benefit options at differing contribution levels. All schemes are, however, required to provide unlimited access (without

¹(1) A medical scheme shall apply to the Registrar for the approval of any benefit option if such a medical scheme provides members with more than one benefit option.

(2) The Registrar shall not approve any benefit option under this section unless the Council is satisfied that such benefit option—
a) includes the prescribed benefits; b) shall be self-supporting in terms of membership and financial performance; c) is financially sound; and d) will not jeopardize the financial soundness of any existing benefit option within the medical scheme “(Medical Schemes Act, Act 131, 1998 Section 33).

any co-payment) to a defined set of statutory minimum benefits called Prescribed Minimum Benefits (PMB). This is designed in a way to ensure that medical schemes provide substantial coverage to their members to guard them against catastrophic costs. This refers to the provision of substantial cover in respect of conditions frequently seen in the general populous. These Prescribed Minimum Benefits (PMBs) were reintroduced by legislation in 2000. The PMBs cover all non-elective hospitalisations and outpatient care for any emergency condition, a specified list of 270 medical conditions (defined by the Council for Medical Schemes as “Diagnosis Treatment Pairs”) and 26 chronic conditions².

The divisions of who has health insurance and who does not, and the reasons behind this wide division is a topic which continues to be debated by numerous and diverse groups of people such as economists, politicians, health policy experts as well as ethicists (Hoogeveen & Özler 2005; Wollard 2002; May 1998; Benatar 1991: 33). The greatest problems in this regard, appear to be those which concern justice – the attempts to find ways in which goods / services can be more equally distributed.

² Detailed explanations of emergency conditions, the 270 Diagnosis Treatment Pairs and the 26 Chronic conditions can be found on the internet website for the Council for Medical Schemes, namely (<http://www.medicalschemes.com>), which is periodically updated.

While that area of research is fascinating, in this research report I will focus on some of the medical schemes in the context of their relationship to their members and the possible ramifications of the Consumer Protection Act in South Africa. To the best of my knowledge, this is an area which has not been researched.

1.2 The need for medical insurance

Medical Aid, or Medical Insurance, for many South Africans has become a non-negotiable necessity. This is due mainly to the fact that it is felt, or is actually a truism, that the level of care and / or the facilities offered at state clinics and hospitals are largely sub-standard (Cullinan, 2006:3). Yet there is a problem because at the same time, the costs of private healthcare, being the medical schemes, doctor's consultations, clinics and hospitals, have progressively become more and more expensive (Schreyögg, 2004: 689).

Private healthcare practice in post-modern South Africa could not survive without medical schemes or other forms of medical insurance in whatever guise. While submission of medical aid claims affords doctors a reasonable guarantee of payment, it simultaneously greatly reduces

the medical profession's bargaining power in fee-negotiations, as it affords the medical insurance companies inordinate leverage (Le Roux, 2004).

In the interests of ensuring that one has access to first-world medical facilities, and in exchange for a monthly premium, medical schemes offer varying degrees of funding for private hospital and medical care. The concept seems quite noble – bridging the gap between the average citizen and world-class medical services, which would ordinarily fall outside of the ambit of one's disposable income. If this is the case, then what is the problem?

1.3 Overview: Concepts of Justice and widening divisions in income and healthcare in South Africa

As previously mentioned, the divisions of who has health insurance and who does not, and the reasons behind this wide division is a topic which continues to be debated by numerous and diverse groups of people such as economists, politicians, health policy experts as well as ethicists (Hoogeveen, & Özler 2005; Wollard 2002; May 1998; Benatar 1991: 33). The greatest ethical issues in this regard appear to be those which concern justice –

the attempts to find ways in which goods / services can be more equally distributed amongst a society.

Three models of justice are particularly evident in the context of healthcare. Each of them generally involves what a given society considers as a fair distribution of resources for its population. They include the tenets of fairness, the ideas of comparative justice and distributive justice (Asch & Ubel, 1997: 1669).

John Rawls (1971: 1-18) in his work *A Theory of Justice* considers justice as absolute equality and fairness. For example, when we consider that South African medical schemes have in the past considered one's race and age (or other distinguishing factors) as a reason to increase their premiums then we note that this does not conform to Rawls's notion of justice-as-fairness.

Comparative justice on the other hand, includes an assessment of the relative meaning people have in receiving a healthcare resource. For example, David Hume was concerned with comparative justice including the recognition of the limited nature of resources. In his model of comparative justice, he strikes a compromise between Rawls' justice as fairness (in which the ideal is

the provision of treatment based on only need) and acknowledgment of the limited pool of resources from which to provide the treatment. In this view, a needs assessment is carried out and treatment is given accordingly (Berglund, 1977: 43-52).

Distributive justice has as its focus the allocation of resources based not just on need, but on what each given society considers as an appropriate distribution of benefits and burdens. In other words, it represents a social consensus on the problems of allocation of rights, duties, benefits and burdens amongst society's members (Dickens, 1994: 315). Distributive justice is particularly important in the developing world context. In South Africa, for example, the gap between the 'haves' and the 'have nots' is widening. Within the general category of poverty, extreme poverty is increasing. Even within the black African population, the inequality brought about by extreme poverty has increased during the last decade (May, 1998).

South Africa has, in practice, a two-tiered healthcare system. Concerning health insurance, it is funded for the most part by the private sector funds such as employer, group and individual contributions. The public sector, on

the other hand, relies principally on government taxation for its survival (Benatar 1991).

According to Mutyambizi (2007: 2-4) the health sector accounts for 8.7% of the country's GDP – 3.5% of this expenditure is in the public sector (serving over 80% of the population) and the other 5.2% of expenditure is in the private sector (serving less than 20% of the population).

The topic of justice in healthcare delivery for all individuals in South Africa is vitally important. Perhaps this is why the current government is working towards a National Health Insurance for clearly in our current South African healthcare situation, little justice, considered as fairness, comparative or distributive is evidenced. As important as this topic is, it is not the focus of my research report.

1.4 Justice as the sub-text in the relationship between medical scheme and member

Justice, in whatever situation conceived is an infallible human concept. Issues of justice should not be confined to only certain times, events and places. Rather it should

be malleable. In this research report I will look at justice broadly through a different frame.

I suggest that it is in the artistry or maleficence, dependant from which perspective one examines the relationship between medical scheme and member, of the scheme's details ensconced in the membership contracts and in the terms / conditions of the medical schemes that one may question the rationale behind the nature of certain exclusions.

In the following chapters I will consider the relationship between medical schemes and their members. Then I will place particular emphasis on the types of medical and other conditions commonly deemed as “exclusions” by the medical schemes industry, questioning their reasoning in the context of justice as equity meaning “that all individuals be provided “equal” opportunities to actualise their health potential regardless of whether the differences in groups are narrowed or not” (Chang 2002: 489).

We can all agree that being in the business of healthcare involves contracts / quasi-contracts, and the exchange of

money for services (Fryback & Lawrence, 1997: 277-279). We can also agree that when people disagree with a model in operation that they may choose to object. Patients and consumers can also voice frustration with how some resources are used (Zeithaml, Berry & Parasuraman, 1996: 32), how some exemptions are articulated and others not (Belèn del Rio-Lanza, *et al.* 2009: 779) and about how long it seems to take for their healthcare needs to be met or their grievances heard (Hall, 2008). These factors all involve justice in some way or another through patient or consumer perceptions of e.g. service, emotions, thoughts, desires and needs. With this in mind I will hold medical schemes to the South African Consumer Protection Act. In this way I will try to show how justice and consumer protection may work in tandem.

To the best of my knowledge, this is an area which has not been previously researched.

Chapter 2: Species of Medical Schemes

The United Nations Organization for Economic Co-operation and Development (OECD) presents a taxonomy that distinguishes between public and private health insurance on the basis of funding source (Normand & Busse, 2000:64). In this view, public funding of medical insurance derives from house-hold or employer income which is then channelled through to the state by means of general or social insurance taxes. In private health insurance, money is paid directly to the risk-pooling entity- the medical scheme. South African medical schemes, with the exception of those closed schemes whose membership is limited to civil servants, are generally privately funded.

Private medical insurance is often colloquially regarded as a voluntary for profit commercial coverage as opposed to “public managed insurance” which is both publically managed and financed. It is important to note that there are quite a variety of medical insurance types globally and that the distinctions between public and private are increasingly blurred.

The public generally assumes that membership of private medical schemes is generally voluntary, yet in some

countries they are not. For example in Uruguay and Switzerland private health coverage is mandatory; in Mexico, it is voluntary (Sekhri&Sayedoff, 2005: 128). In addition, as Sekhri&Sayedoff note, there are global variants in contributions to medical schemes, as although they tend to be rated by risk or community-risk, this is not always the case. Perhaps one of the most striking myths surrounding private medical schemes is that they are privately owned. Australia, Ireland and India are examples provided which point out that the largest private health insurance companies are publically owned (Ibid).

So we can see that there are some common misunderstandings an ordinary person may have about private health insurance companies because in their types, management and status, they are not globally categorical. Importantly, there is variability in the role (or roles) that private health insurance companies may play in a country's health financing system. In some countries, enrolment of its citizens in a health insurance company may be voluntary, the contributions are community – rated, yet it may be managed as a public company. In others, a publicly funded health insurance company may consist in mandatory enrolment, be income-based, and

managed as a non-profit entity. So to typify all health insurance companies as the same is a misconception.

Debate has developed over the need to shield patients from various undesirable features of the perceived paternalistic approach of “managed care”. What is meant by managed care is the scheme’s micro-management and involvement in areas such as disease management, utilization review, physician profiling and the use of broad spectrum guidelines and protocols (Holčik, 2001:1).

This backlash is now being vociferously expressed by the movement known as “consumer directed health care”, which seeks to re-establish the economic dominance of the doctor-patient relationship, free from interference by health insurers (Hall, 2008:586).

Consumer-driven health plans have incorporated health benefit options available to employees in many large companies (Parente et al., 2004: 1190-1191). In the interests of improved staff health and hence greater productivity, many South African employers prefer their employees become members of such medical schemes.

A consumer-driven health plan purports to involve the consumer in their own healthcare decision-making. There are different ways of formulating this, but it is interesting to note the use of industrial psychology in some of the methods. For example, some medical schemes employ a technique that provides the member with his or her own 'healthspending' or 'health savings account'. From this account, the member chooses and has the opportunity to purchase his or her healthcare service/s. Usually there is a form of a major medical coverage clearly indicated as a benefit in this scheme design; a 'wrap-around' giving the member security (Ibid). Should the member spend all of his or her savings/spending account in a given year, then the member is compelled to use his or her personal funds for healthcare needs until the deductible obligation is met (ibid).

While this particular design varies from scheme to scheme (it can be planned to cover expenditures in excess of the deductible in part or wholly) emphasis is placed on the choices available to a member. Some medical schemes, in the name of informed decision-making, provide their members with information concerning their healthcare providers, which may include

their educational background, experience , fees for service and what are called their 'quality ratings'(ibid).

Information regarding one's medical scheme is usually available on the internet in order to ensure easy access (Christianson, Parente, and Taylor, 2002: 49), but South African Medical schemes, to be fair, cannot publicise specific information about health care providers, including physician education and experience, prices, and 'quality ratings'. This is because such acts would contravene local anti-competitive legislation.

Certainly, the idea of a 'quality rating' would cause at least a flurry of feathers in the healthcare profession community as an assessment of the quality of the doctor-patient / healthcare professional –patient relationship is often subjective and extremely difficult to quantify or qualify on a large scale. However, from a legal perspective, the publication of e.g. a healthcare professional's poor 'quality rating' could be considered defamatory if publicized.

In this very brief synopsis, I have tried to illustrate the context within which the South African medical aid sector relates to the subject matter of this research report.

Chapter 3:Phraseology of Medical Aid

Contracts

In terms of section 2.4 of the Health Professions Council of South Africa National Patients' Rights Charter,

“A member of a health insurance or medical aid scheme is entitled to information about that health insurance or medical aid scheme and to challenge, where necessary, the decision of such health insurance or medical aid scheme relating to the member “(Health Professions Council of South Africa (i), 2008)

The key information, as far as many consumers / members are concerned, is what their medical scheme will not pay for. In this regard, it is necessary to examine specific exclusions as applicable in the South African Medical Aid industry.

What follows is a brief examination and discussion of the exclusions that are applicable to five of the largest medical schemes in the country.³

³Membership figures for the below-mentioned medical schemes as at January 2011 are:
Discovery: 2 500 000;
Fedhealth: 75 000;

3.1 Specified Exclusions

While the position of a person who is interested in the types of exclusions may differ according to his or her particular healthcare interests, I have chosen the following simply to demonstrate some of the different types of exclusions. (The table below is intended to serve as illustrating most if not all exclusions that could affect a consumer on a day to day basis, and as such, the exclusions of the five medical schemes cited were deemed sufficient for the purpose this research report.)

Table 1: Comparison of exclusions between Discovery, Spectramed, Fedhealth, Oxygen and Bankmed

No.	Exclusion:	Discovery	Spectramed	Fedhealth	Oxygen	Bankmed
1	General Elective Cosmetic Procedures	√	√	√ (unless directly caused by or related to illness, accident or disease)	√	unless medically necessary and pre-authorised
2	Breast Reductions (inclusive of healthcare services related thereto)	√	√	unless medically necessary and pre-authorised	√	
3	Breast Enlargements (inclusive of healthcare services related thereto)	√		unless medically necessary and pre-authorised		
4	Breast Reconstruction		cosmetic	unless mastectomy following cancer and pre-authorised		
5	Gynaecomastia	√		√	√	
6	Rhinoplasties			for cosmetic purposes		
7	Abdominoplasties and the repair of divarication of the abdominal muscles			√		

Oxygen: 91 490;
Spectramed: 83 000; and
Bankmed: 100 000.

8	Obesity (inclusive of healthcare services related thereto)	√	√ (including surgery in respect thereof)	√	√	√
9	Frail care (inclusive of healthcare services related thereto)	√	√			√
10	<u>Infertility (inclusive of healthcare services related thereto):</u> Assisted Reproductive Technology (ART): In-vitro fertilization (IVF): Gamete Intrafallopian tube transfer (GIFT): Zygote Intrafallopian tube transfer (ZIFT): Intracytoplasmic sperm injection (ICSI):	√	√	√ √ √ √ √	√	√
11	Vasovasostomy (reversal of vasectomy)			√		
12	Salpingostomy for reversal of tubal ligation			√		
13	Wilfully self-inflicted illness or injury (inclusive of healthcare services related thereto)	√	√	unless covered by PMB's	only by beneficiary	√
14	Alcohol, drug or solvent abuse	√		√		
15	Wilful and material violation of the law or during a period of imprisonment (inclusive of healthcare services related thereto)	√	√			
16	Wilful participation in war, terrorist activity, riot, civil commotion rebellion or uprising (inclusive of healthcare services related thereto)	√	√	unless covered by PMB's		irrespective whether wilful or not
17	Experimental, unproven or unregistered treatments or practices	√	√			
18	Search and rescue	√				
19	Side-effects or complications of excluded treatments (to the extent that same are not provided for in the list of Prescribed Minimum Benefits		√			
20	Failure to follow the advice of a medical or dental practitioner or to undergo health services/treatment as recommended by a medical or dental practitioner		√	only if such failure is deliberate	√	
21	Health care services relating to injuries sustained during participation in professional sport, speed contests and speed trials		√			
22	Health care services obtained out of the borders of South Africa		√		except for Lesotho and Swaziland	
23	CT Angiogram of coronary vessels		√			
24	Any benefit not specifically stated in the scheme rules		√	√		
25	Treatment in respect of which a 3rd party may be liable	√	√			√
26	Holidays for recuperative purposes			√	√	√

27	Erectile dysfunction			√ (including surgical procedures in respect thereof)	√	√
28	The purchase of medicines prescribed by a person who is not legally entitled to do so			√	√	√
29	Costs for services rendered by (medical) personnel not registered with a professional body constituted in terms of any law			√	√	√
30	Services that do not relate to any sickness condition, including but not limited to examinations for insurance, employment, visas, pilot and driving licences or school readiness tests				√	√
31	Sleep Therapy			√	√	√
32	Any drug or medicine not registered by the Medicines Control Council or similar authority or medicines not registered for that specific condition			unless Section 21 approval obtained & pre-authorised by relevant managed healthcare programme	√	
33	Orthognathic (Jaw Bone) Surgery		√		√	
34	Any specialised drugs that have not convincingly demonstrated a survival advantage of more than 3 (three) months in metastatic solid organ malignant tumours			√	√	
35	Cochlear implants			√	√	
36	Contraceptives (oral or otherwise), IUCD's, parenteral and foams			√ (including when used for skin conditions)	√	
37	Anabolic Steroids and Immunostimulants			√		
38	Health care services that, in the opinion of the medical or dental adviser, are not appropriate and necessary for the symptoms, diagnosis or treatment of the medical condition at an affordable level of service and cost			√	√	√
39	<u>Alternative Health Therapists:</u> Herbalists: Iridology: Reflexology: Therapeutic Massage: Ayurvedics:			√ √ √ √ √		

	<u>Blood Products:</u> Erythropoietin:			unless pre- authorised		
40	Hemopure (haemoglobin polymer synthesised from bovine haemoglobin)			√		
	<u>Maternity:</u> 3D and 4D scans			√		
	2D scans			No more than two, unless motivated for an appropriate medical condition		
41	ante-natal classes/exercises			√		
	<u>Cancer Treatments:</u> trastuzumab for the treatment of HER2- positive early breast cancer			unless forms part of public sector protocol and is authorised by relevant managed healthcare programme (if exceeds 9 week regimen)	√	
	any specialised drugs that have not convincingly demonstrated a survival advantage of more than 3 (three) months in metastatic solid organ malignant tumours, for example sorafenib for hepatocellular carcinoma, bevacizumab for colorectal and metastatic breast cancer			unless forms part of public sector protocol and is authorised by relevant managed healthcare programme	√	
42	Imatinib in the treatment of chronic myeloid leukaemia and gastrointestinal stromal tumours					
43	New indications for existing medicines that have not been reviewed by the relevant managed healthcare programme			√		
44	Smoking cessation and anti-smoking preparations			√		
45	All benefits for clinical trials unless pre- authorised by the relevant managed healthcare programme			√		
46	Growth Hormone			Unless pre-authorized		
47	Organ Donation			excluded unless recipient is member / dependant of member of the scheme		

48	Haemopoietic stem cell (bone marrow) donations			excluded unless recipient is member / dependant of member of the scheme		
49	MRI Scans			if ordered by General Practitioner, unless no reasonable access to specialist		
50	Uvulo palatal pharyngoplasty (UPPP and LAUP for snoring)			√		
51	Autopsies			√		
52	Costs for medical treatment as a result of exposure to Nuclear or Radioactive waste			√		
53	Cryo-storage of foetal stem cells and sperm			√		
54	Telephonic consultations			√		√
55	<u>Hazardous Activities:</u> Military / Para-military service: Advanced rope climbing: Rope assisted climbing: Rock Climbing: Power boat racing: Scuba Diving > 40m depth					√ √ √ √ √ √
56	Travelling Expenses			√	√	√

Notes

- i. The aforementioned exclusions were sourced from the internet websites of the relevant medical schemes during August 2010, and as at such date, were current and up to date (Bankmed, 2010; Discovery Health, 2010; Fedhealth Medical Scheme, 2009; Oxygen Medical Scheme, 2010; Spectramed Medical Scheme, 2010).
- ii. The above exclusions do not take into account provisions in relation to Dentistry and Optometry benefits, but relate

to medical conditions and other factors that are frequently seen in practice.

- iii. Conditions and / exclusions such as "Blue Door" which bare a statistically fractional significance, have been excluded from the above list.

3.2 Discussion:

Interestingly, with respect to its above mentioned exclusions, Fedhealth defines “medically necessary” as services or supplies that meet all of the following requirements:

- The desired treatment or procedure must be required to restore normal function of an affected limb, organ or system;
- No alternative exists that has a better outcome, is more cost-effective or has a lower risk;
- They are accepted by the relevant service provider as optimal and necessary for the specific condition and at an appropriate level to render safe and adequate care;

- They are not rendered or provided for the convenience of the relevant beneficiary or service provider; and
- Outcomes studies are available and acceptable to the scheme in respect of such services or supplies.

It is submitted that the above constitutes an exceptionally narrow window of what is capable of being deemed “medically necessary”. It does not allow for new and innovative treatments or for multi-faceted medical problem solving. It seems to constitute a term that is both unconscionable and unjustly restrictive.

For example, the member, in a situation of a treatment or procedure deemed “medically necessary” is assured that “outcome studies are available and acceptable to the scheme in respect of such services or supplies”. While members are assured that outcome studies are available and acceptable, it may be argued that in the interests of fairness, these outcome studies should be available and acceptable to members as well. This is because 1) the average scheme member has no knowledge of the empirical studies which ground the medical scheme decisions, particularly whether they represent current

knowledge, and 2) in a situation of a medically necessary treatment or procedure, it is unlikely that the scheme member will even recall that they may have a chance to question what the medical scheme has deemed appropriate action.

As mentioned earlier, the business of healthcare involves an exchange of money for services (Fryback & Lawrence, 1997: 277-279). From the perspective of a medical scheme, it is in their interest to provide benefits at minimum cost to themselves. It is of utmost importance to consider that equity means that all individuals be provided with equal opportunities to realise their health potential (Caplan, et al. 1999: 854-855). Without knowledge concerning the facts behind the scheme's decision of what they consider 'acceptable' the member remains ignorant. In this example, we can see that the notion of equity is sorely lacking.

Furthermore, why should one merely be entitled to be restored to normal function / health as opposed to optimum function / health? This question is particularly pertinent for sportsmen and / or persons who lead a largely active lifestyle. Considering how low the generally accepted standard of normal functioning / health is,

surely, if relevant and appropriate, members should be entitled to restorative treatment aimed at the maximum possible benefit? In this way, not only will the medical schemes facilitate the evolution of proactive medicine, but also provide sufficient value to the Principalist pillars of patient (scheme member) autonomy and beneficence. It is pertinent to note at this point that autonomy (or the right to self-determination) is a fundamental ethical principle underlying informed consent (Dhai&McQuoid-Mason, 2011), which is itself a formality required for any medical intervention and the information given must assist the patient in making the best possible decision (Ibid). It is submitted that the best possible decision in such circumstances would be the restoration of optimum functioning and / or health.

The implicit corollary of this, however, is that Fedhealth gives the impression that “only the best proven drugs, treatments or procedures shall suffice”. It may well be difficult for such medical schemes to insist on generic substitution of patented drugs in the face of a member objection. This aspect will be discussed further under the heading of “Original versus Generic Drugs”.

***3.3 Problematic Express / Implicit Provisions in
respect of the above Exclusions:***

Inasmuch as the above exclusions are phrased with varying degrees of comprehensiveness and elaboration, certain exclusions, whether express or implied, require further examination:

***3.3.1 Health care services necessitated as a result of
side-effects caused by the use of prescribed (and
approved) drugs:***

Although none of the schemes cited above expressly exclude health care services necessitated as a result of side-effects caused by the use of prescribed (and approved) drugs, numerous schemes, including several cited above, have refused to pay for the treatment of the side-effects / consequences of certain approved treatments. The “justification” for such repudiation is that the corrective procedure falls within the vague ambit of one of the cited exclusions, and hence cannot be paid for with scheme funds.

In truth, if the drugs and / or treatment approved by the medical scheme were the direct cause of the condition

from which the member now suffers, the scheme is ethically bound, from the perspective of both justice and non-maleficence, to pay for any treatment necessary to correct such conditions, regardless as to whether one of the scheme's exclusions is phrased broadly enough so as to be capable of being interpreted as covering the condition in question. Not paying for corrective treatment would be tantamount to paying for knee or hip replacement surgery but refusing to pay for requisite physiotherapy thereafter. Indeed, the physiotherapy was only necessitated on account of the orthopaedic surgery, but it was a known consequence thereof, without which, the surgery would lose much of its intended benefit.

On the basis that none of the aforementioned medical aids exclude health care services necessitated as a result of side-effects caused by the use of prescribed (and approved) drugs, it is submitted that any requisite corrective treatment should be interpreted as being an implied inclusive benefit of the scheme.

3.3.2 Breast Reconstruction for Females due to Mastectomy:

In these times, the psycho-social healthcare model which includes a holistic view on healthcare is promulgated in

medical school teaching and practice. In this way of thinking, the patient's body is part of the medical dynamic, yet it is realised that a patient is not just a body.

Rather he or she is a whole being living in a web of social relationships. By social relationships, we mean that he or she lives in a particular time and place and inevitably his or her culture, traditions, media influences, religion, education, etc. are part of his or her social identify.

While breast cancer is predominately found in females, it may also occur in males. (Fentiman, Fourquet&Hortobagyi, 2006: 595) Applicable to both sexes, there are some surgical procedures which are practiced for removal of carcinoma of the breast such as a 'lumpectomy' where, because of the type, location, and size of the tumour, it is feasible.

A mastectomy,⁴ which is the surgical procedure to remove a breast and related lymph glands remains the most common surgical procedure for breast cancer treatment (Martin,2007: 432). The removal of any malignant tumour in one's body is, by its very nature, not an elective

⁴Removal of both breasts is commonly called a total mastectomy.

procedure. Such procedures are performed to save or at least prolong the patient's life.

While no literature is available concerning the psychological responses of males post breast cancer surgery, it is quite different with women. It is part of the history of humans as evidenced through literature and the arts that the female breasts are directly linked to ideas-be they right or wrong-about fertility, motherhood, femininity, and 'womanhood'. It would follow that in cases of breast cancer in females a good outcome should aim to combine both the physical and mental well-being of the patient. (Passik, Newman, Brennan & Holland, 1993: 226; Stevens et al. 1984: 619).

Frequently, women who have undergone mastectomies develop post-operative depression, diminished self-esteem, and impaired sexual, social and occupational functioning, as well as other psychiatric conditions as a direct result of their apparent loss of "womanhood" (Al-Ghaza, Fallowfield & Blamey, 2000: 1938; Stevens et al, 1984: 619).

Due to these factors, and admittedly there will be degrees of individual variation of psychological response, there is

good reason to argue that, for those women who believe they need breastreconstructive surgery, they should receive it. This would support the contemporary emphasis on viewing the patient as an entire person. It is submitted that regardless whether a particular medical aid specifically excludes cosmetic surgery or breast augmentation surgery (which term is periodically and incorrectly used synonymously with “breast reconstructive surgery”), a member’s claim for breast reconstructive surgery as a result of a mastectomy for a breast malignancy should not be repudiated.

3.3.3Breast Augmentation / Enlargement – (medical grounds):

Although not as dramatic as breast reconstructive surgery necessitated by a mastectomy, sound psychiatric / medical reasoning for breast augmentation (enlargement) should be considered for coverage on a case-by-case basis by the medical schemes. Justifiable reasons might include, for example cases in which there is abnormal breast development or in cases in which clinical depression (in various guises) occurs because the woman considers that she is not “feminine” enough (Schlebusch& Levin 1983: 481).This is not to suggest that all women with “small” breasts should automatically

qualify for breast enlargement surgery, but rather that if the patient presents with a genuine psychiatric or borderline psychiatric condition on account of her breast size, it would only be fair and just that her case be considered on its individual merit.

Every member is an individual with their own unique set of personal and medical circumstances. Hence, five members may require the same surgery for five different reasons. For the scheme to state that they shall not pay for the surgery because it falls under the category of cosmetic treatment would be to disregard the principles of justice and fairness, and would necessarily imply that all of the aforesaid five members presented with the same medical requirements, which would be a gross misinterpretation of the facts.

Indeed, inasmuch as medical ethics obliges doctors to treat their patients as individuals, why should medical aids be permitted impose blanket bans on certain procedures / treatments, irrespective of the rationale therefore?

Once again, from an economic perspective, should the patient's psychological morbidity become sufficiently

significant, the scheme may well find that the cost of psychological / psychiatric treatment outweighs the cost of the desired surgery.

3.3.4 Breast Reduction (Mammoplasty) – medical grounds:

Breast reduction surgery can be motivated from a medical perspective because of the neck, shoulder and back pain that may be caused by the excess weight increasing the strain on the musculature of the affected areas. In such cases, the muscles and skeletal system are incapable of supporting the increasing weight of the breasts (Klassen et al., 1996: 454). This pain can, in certain circumstances, be significant. Furthermore, the woman in question is likely to feel “ungainly” and her self-esteem (and general psychiatric health) is adversely affected by breasts that are out of proportion to the rest of her body.

A British study in 1996 showed that breast reduction surgery produced substantial positive changes in patients’ physical, social and psychological function. The proportion of cases of possible psychiatric morbidity fell from 41% before surgery to 11% six months after

treatment. The study provides empirical evidence that supports the inclusion of breast reduction surgery in NHS (National Health Insurance) contracts (Ibid).

From an economic perspective, regardless of whether one refers to breast reconstruction, augmentation or reduction surgeries, if a woman is prescribed anti-depressant medication and is required to consistently consult with a psychiatrist, the cost of such medication and treatment is likely to significantly outweigh the cost of the so-called “cosmetic” procedure. Consequently, permitting such procedures makes not only fiscal but holistic healthcare sense.⁵

3.3.5 Infertility

Infertility treatments such as In-vitro Fertilisation (IVF), Assisted Reproductive Technology (ART), Gamete Intrafallopian tube transfer (GIFT), Zygote Intrafallopian tube transfer (ZIFT) and Intracytoplasmic

⁵It is only fair at this juncture to acknowledge that Fedhealth and Bankmed do in fact make allowances for cosmetic procedures necessitated by medical conditions.

sperm injection (ICSI) are expensive (Phillips et al., 2000: 95 - 106).

One can understand, if only from a financial perspective, the initiative of the medical aids to exclude such treatments from their members' benefits. That said, all of the above treatments, amongst others, have been shown to increase the likelihood of a full-term pregnancy and subsequent live birth when administered under medically appropriate conditions. The problem is that it is very difficult to determine which procedure is in fact "medically appropriate" for an individual patient.

Section 12(2) of the Constitution specifically enshrines the right of every person to bodily and psychological integrity, including the right to make decisions about reproduction (Constitution of the Republic of South Africa, Act 108 of 1996).

The decision whether or not to fund treatment of infertility often centres around resource allocation, the argument being that either that the (expensive) infertility treatment is either not medically necessary or is an elective procedure that the medical aid is not obliged to cover, and that if a given scheme were to cover such treatment

it would unnecessarily deplete the resources needed to treat other members in more dire circumstances.

However the principle of justice is a very important factor in resource allocation decisions. Using this principle, a more social approach to the distribution of resources is employed where the needs of others and not just the individual patient are taken into consideration (World Medical Association Declaration on the Rights of the Patient, 2005). The justice principle requires that where choices have to be made between patients for particular treatments, decisions must be based on sound medical criteria without discrimination – all patients to fair selection procedures. (Dhai & McQuoid-Mason, 2011).

From the perspectives of patient autonomy and justice, if a member is paying for medical insurance to cover the costs of unforeseen medical circumstances as and when they may arise, and such member has a constitutionally entrenched right to make all relevant decisions regarding their reproduction, including which available technological innovations to utilise, then on what basis (legal, ethical or otherwise) could a medical scheme exclude such treatment from its payment protocol? It is submitted that in acknowledging their members' Constitutional rights, a medical scheme should at least make a meaningful

financial contribution towards any medically necessary treatment of infertility.

3.3.6 Health care services in respect of injuries from professional sport:

When we consider the ideals of fairness and justice in the context of sports activities we must then also consider the question of why professional sport is distinguished from amateur sport. One of the many benefits to playing professional sport is that medical care is readily available, and that referees and coaches are becoming more educated regarding the prevalence and nature of sports injuries as opposed to amateur sport. It could thus be argued that from a medical standpoint, one is more likely to be injured in an amateur sport than its professional equivalent.

A possible solution to this quandary is to examine certain high-risk sports, whether amateur or professional, on a case by case basis.

3.3.7 Health care services in respect of pre-determined “Hazardous Activities”:

What seems to create difficulties with a provision such as this is who determines which activities are deemed to be sufficiently hazardous. Bankmed defines, amongst others, military / para-military service, advanced rope climbing, rope assisted climbing, rock climbing, powerboat racing and scuba diving at depths greater than 40 meters as “hazardous”.

If one is to be critical, then where does one draw the line between “advanced” rope climbing and ordinary rope climbing; between powerboat racing and super bike racing; or between scuba diving at depths greater or lesser than 40 meters? These distinctions appear to be arbitrary, and as a result, unfair and unjust. In fairness, the risk in scuba diving is more closely linked to one’s training and experience than merely the depth that one dives at. Other seemingly hazardous activities, such as rugby union, rugby league, micro-lighting, skydiving, boxing, wrestling and martial arts are conspicuously excluded from the above list, yet arguably carry a greater risk of injury to life and limb than those expressly cited. It is submitted that clear and concise empirical research by a scheme-independent body be included so that the public can understand the justification for such specified

exclusions. What scheme members require in this regard, in many of the unexplained exceptions, is an expectation of being treated fairly and reasonably.

3.3.8 Contraceptives:

This exclusion appears strange for several reasons. The first is the direct comparative cost to the scheme of paying for contraceptive devices / treatments on the one hand as opposed to paying towards the cost of gynaecological visits, child birth and all medical expense of the child for the first 18 years of its life on the other hand.

Furthermore, low-dose triphasic oral contraceptives have been shown to be an effective medical treatment for skin conditions such as acne vulgaris (Lemay et al., 1990: 8 - 14) as have so-called combined oral contraceptives (Koltun et al., 2008: 249).

An argument that could be raised by a scheme as justification for not paying for contraceptives is that it encourages sexual activity and / or promiscuity. This, however, must be countered with the post-modern reality that children / young adults are becoming sexually active

at a progressively younger age in any event (Kaestle et al., 2005: 777), and the potential payment for contraceptives by medical aids would not have a material bearing on the level of promiscuity in society. Indeed, there may be a greater risk to society in an increase in unplanned pregnancies, unwanted children and the linked socio-economic costs that are inextricably linked thereto.

3.3.9 Smoking cessation and anti-smoking

preparations:

The financial burden on the health infrastructure that is attributable to smokers is significant on account that tobacco is estimated to be the largest single cause of premature deaths in developed countries (Peto et al., 1992: 1268). To be more specific, smokers are more likely to develop emphysema (Auerbach et al., 1972: 853), oesophageal cancer (Funkhouser & Sharp, 1995: 1119), lung cancer (Cornfield et al., 2009: 1175) and pneumonia (Almirall et al., 1999: 375), amongst respiratory and other diseases, than are non-smokers.

Recent developments in the South African Tobacco / Anti-smoking legislation have begun the process of curbing the very destructive habit of smoking, but this is

not enough. Smoking, and specifically the nicotine contained in cigarettes, is addictive (Dani& De Biasi, 2001: 439). In the interest of the health of their members, it is submitted that medical aids are ethically bound, from both a beneficent and a just perspective, to provide payment for proven methods of assisting in the process of smoking cessation. Not only will society (specifically the general health and wellbeing thereof) as a whole benefit, but the direct cost of anti-smoking treatments is but a fraction of the cost of treating smoking related conditions such as those cited above. It is consequently submitted that medical aid companies should be ethically bound, and financially responsible to pay for anti-smoking treatments.

3.3.10 Organ Donation:

The majority of organs for transplantation come from cadavers, but as these have failed to meet the growing need for organs, attention has turned to organs from living donors (Truog, 2005: 444). Organ donation by living donors presents a unique ethical dilemma, in that physicians must risk the life of a healthy person to save or improve the life of a patient. Transplantation surgeons

have therefore been cautious in tapping this source (Ibid). However, as surgical techniques and outcomes have improved, this practice has slowly expanded.

Fedhealth excludes payment for organ donation unless the recipient is a member / dependant of a member of their scheme. There is no indication as to why the costs of the donor should not be covered if the recipient were on another medical scheme, or not a member of a scheme at all.

In the alternative, it would be unreasonable to expect a donor to pay for all of the costs associated with a donation of an organ (or part thereof), particularly if performed entirely for beneficent reasons. If the would-be recipient is a member of a medical aid, it is submitted that such medical scheme has an obligation to pay for life-saving surgery, which in this case is organ donation. The costs of such procedure would not only include the costs of the recipient, but also those of the donor, without whom such life-saving surgery would not be possible. For a medical scheme to exclude payments for organ donation, it would necessarily be disregarding all four bio-ethical pillars, namely, respect for patient autonomy, justice, beneficence and non-maleficence.

To be more specific, if both recipient and donor, in knowing the associated risks, autonomously elect to undergo surgical transfer of tissue from donor to recipient, and there is a scientific likelihood of success, then it would not be fair or just to deprive the recipient of the opportunity of lifesaving treatment on account of the cost. Remember, the primary function of medical insurance is to fund the expenses associated with unforeseen medical procedures and treatments, and the need for organ donation would invariably not have been contemplated in advance by the would-be recipient, making the treatment unforeseen and lifesaving. It is hence difficult to understand how payment for organ donation could be excluded for any other reason besides being an arbitrary mechanism of limiting member benefits.

Furthermore, it is submitted that from an economic perspective, the cost of a kidney transplant for example is substantially lower than that of on-going, long-term dialysis, which the scheme would otherwise pay for. Medical schemes could, in the circumstances, generate significant goodwill by becoming innovative and including procedures such as organ donation on their list of

approved treatments / procedures, and in so doing, illustrate to the public how such scheme has incorporated bioethics into a dynamic funding protocol for the benefit of the member (as well as the fiscal benefit of the scheme).

3.3.11 Haemopoietic stem cell (bone marrow)

donations:

There should be no difference in principle between payment structures for bone marrow donation and 'ordinary' organ donation, as above.

3.4 Innovative Express / Implicit Provisions in respect of the above Exclusions:

3.4.1 Failure to follow the advice of medical practitioners:

If a member experiences certain complications or a worsening of their underlying condition on account of failing to heed the advice of their medical practitioner, then there exists no justification for the relevant medical scheme to be compelled to pay for any subsequent treatment brought about by such failure. Such failure could in fact be seen as being tantamount to wilfully (voluntarily) inflicted injury or harm on one's self, and if

such conduct was wilful, regardless of the subjective reasoning involved, the member should on all accounts be responsible for the costs of remedying any damage caused thereby.

3.4.2 Medicines prescribed by a person not legally entitled to do so:

Only qualified medical doctors who are registered with the Health Professions Council of South Africa are authorised to formally prescribe medications. This is so in order to ensure that if the medication was incorrectly prescribed, there exists a right of recourse against the doctor with his / her professional regulatory body and / or litigiously in Court, whether in terms of a civil suit or a criminal charge (dependant on the circumstances).

Members must know that by purchasing medication prescribed by someone not authorised to do so, they are risking their lives and health voluntarily, and hence exposing themselves to significant medical costs for which the medical schemes should not have to bear any responsibility. This provision is clear, concise and specifically intended to protect the members' interests,

and it is submitted that such provision should be cited in every medical aid contract.

3.4.3 Anabolic Steroids:

Steroids are prescribed for differing reasons. There are two broad categories of steroids, namely cortico-steroids, being any steroid hormone synthesized by the adrenal cortex (Martin, 2007: 168), and anabolic steroids, being synthetic forms of male sex hormones (Martin 2007: 28).

Cortico-steroids (such as budesonide) assist in broncho-dilation (Barnes et al., 1998: S1), whilst anabolic steroids such as deca-durabolin have been used to provide anti-inflammatory relief to injured joints and muscles due in part to increased haemoglobin levels (Kotler, 2000: 629), Testosterone Cypionate to intentionally stunt one's growth in the treatment of Gigantism and metastatic breast cancer (Lupulescu, 1998: 2265) (Eugster&Pescovitz, 1999: 4382) and various testosterone derivatives such as prednisone are being used effectively as part of the treatment regimen of certain types of cancer (Tannock et al., 1996: 1756; Tannock et al., 1989: 590). From the above, an argument could be made that

anabolic steroids properly prescribed for such legitimate purposes should be paid for out of scheme benefits.

However, it seems that the largest demographic in terms of anabolic steroid use is in respect of illegal performance enhancement in sport and / or for leisure and recreational use (Parkinson & Evans, 2006: 644-651). Steroid use, and particularly at levels greater than relevant therapeutic doses, is linked to severe side-effects such as liver damage (See et al., 1992: 73), kidney damage (Daher et al., 2009: 717), gynecomastia (Babigian & Silverman, 2001: 240), impotence (Bickelman et al., 1995: 158), heart attacks (Welder & Melchert, 1992: 61) and certain types of cancers (Nieminen et al., 1996: 1580).

For these reasons, in addition to the fact that the use of such drugs would invariably not be in line with a recognised therapeutic protocol, the medical schemes are justified in excluding payment for anabolic steroids. It must however be reiterated that *bona fide* and legitimate use of steroids for medical purposes should be considered for payment by the relevant scheme.

3.5 Money-Saving Mechanisms for Medical Schemes:

3.5.1 Original versus Generic Drugs:

An original “patented” drug is regarded as a pioneer in its niche category, having been subjected to thousands of hours of research and development. As such, patented drugs are available at a premium in order to offset such costs. Generic drugs are those utilising the same active ingredients as the patented drugs, and are generally made available once the patent on the original drug expires (Bae, 1997: 87). Medical Aid companies frequently pay only for the cost of the generic drug because the patented drug is viewed as an unnecessary expense.

“For the purposes of drug approval, the interchangeability of a generic drug and the corresponding brand-name drug is based on the criterion of “essential similarity”, which requires that the generic drug have the same amount and type of active principle, the same route of administration, and the same therapeutic effectiveness as the original drug, as demonstrated by a bioequivalence study.”

(Borgheini, 2003: 1578)

Difficulties materialise, however, when the efficacy of the generic drug is not congruent with that of the patented drug, or alternatively were the generic drugs causes certain adverse reactions that the patented drugs do not. Published findings indicate that particular drugs may not be ideally suited for generic substitution when a patient has already been taking that drug (Tschabitscher et al., 2008: 63). A member would thus not be physically able to continue on the generic drug and would of necessity be forced to use the patented drug. Yet the scheme would invariably only pay the equivalent of the price of the generic drug, with the difference in price often being rather significant. In such circumstances, it is only fair and just for the medical aids to re-instate their coverage of the patented drug in the interests of fairness and non-maleficence to their members.

Doctors frequently stipulate on patients' scripts the words "do not substitute" or the like, having their own medical reasons for doing so. A particular individual patient may react adversely to a generic and not so in respect of the patented drug. Although this theoretically should not happen, in reality it does. In this regard, and in the absence of suspicious conduct by the prescribing doctor

(possibly in relation to receiving kickbacks from drug companies), the medical schemes are obliged to abide by the doctor's instruction to "not substitute".

For the sake of completeness, it must be stated that Section 47 of the Medical Schemes Act, Act 131 of 1998, provides for a grievance procedure in this regard, in that:

(1) The Registrar shall, where a written complaint in relation to any matter provided for in this Act has been lodged with the Council (being the Council for Medical Schemes), furnish the party complained against with full particulars of the complaint and request such party to furnish the Registrar with his or her written comments thereon within 30 days or such further period as the Registrar may allow.

(2) The Registrar shall, as soon as possible after receipt of any comments furnished to him or her as contemplated above, either resolve the matter or submit the complaint together with such comments, if any, to the Council, and the Council shall thereupon take all such steps as it may deem necessary to resolve the complaint.

One can easily see though that this process is both inherently bureaucratic and time consuming, and hence does not necessarily deal with the cause of complaint within the realms of medical / financial urgency as experienced by the member.

Members should thus be both entitled and encouraged, in circumstances of their claims for patented drugs being repudiated by their medical scheme in favour of the generic equivalent, to request to see the clinical research / bioequivalence study proving that the generic is just as effective and has no greater side-effects than the patented drugs. In the absence of such research, it is submitted that the medical scheme should not refuse to pay for the patented drug. Furthermore, as there is an international expansion of the counterfeit generic drug trade particularly in developing countries, it would be prudent to be flexible in the position that medical schemes take concerning generic drugs (McNeil, 2000: 1-5; Foster, 1991:1213-1214).

3.5.2 Payment of Service Providers at Medical Aid

Tariff:

The Doctor-patient relationship is quite unique. It contains elements of not only general law of contract, where the patient pays for services rendered, but also a fiduciary duty of the doctor. This duty requires that the onus is upon the doctor to treat the patient as comprehensively as may be necessary, to spend sufficient time with the patient during a consultation in order to ascertain the cause of the complaint and its consequent remedy, and to hold paramount the best interests of the patient above all other considerations (Health Professions Council of South Africa (ii) 2008).

Indeed, as Hall (2008) reminds us: The most conspicuous aspect in which the law alters the normal contractual status of medical care is to declare in a variety of contexts that physicians owe fiduciary-like duties to their patients. Multiple cases say something to the effect that there is more between a patient and his physician than a mere contract under which the physician promises to heal and the patient promises to pay.

There is an implied promise, arising when the physician begins treating the patient that the physician will refrain from engaging in conduct that is inconsistent with the

“good faith” required of a fiduciary. The patient should, we believe, be able to trust that the physician will act in the best interests of the patient thereby protecting the sanctity of the physician-patient relationship (Hall, 2008).

Particularly in emergency situations and / or where the expertise of a specific clinician are sought, the quasi-fiduciary nature of the physician’s role, the vulnerability and possible incompetence of the patient, the exigency that often surrounds illness, and the tremendous complexity of modern medicine all serve to impair the prospects for effective bargaining over the scope and nature of treatment rendered by the physician (Siliciano, 1991). The patient consequently requires the certainty that their medical scheme will cover the cost of the attending doctor in the absence of time for such patient to shop around and locate the most cost effective clinician.

However, if medical aid schemes set a tariff in terms of which a clinician will be paid at a rate which does not bear a realistic nexus to a market related cost, taking into account the said clinician’s academic qualifications, experience, overheads and the need to make a profit on his charge-out rate, then the clinician is being pushed to spend the minimum time necessary with the patient in

order to have capacity to consult with more patients per day. This economic coercion has a substantial and detrimental effect on the level of care shown to the patient.

It is a given that a good doctor should know how to manage time. When a patient's symptoms are straightforward it can be argued that a doctor can accurately define and explain to a patient in a clear and accessible language the problem, a discussion concerning proposals for treatment, and patient reflection within a twenty minute visit. However, not all complaints are straight-forward and complicated problems cannot be solved so quickly.

As Groopman (2008: 88) writes:

A discerning doctor will recognise when more time is needed to ask questions and explain his thinking. In such instances, the appointment may need to be extended or a follow-up visit scheduled as soon as feasible. Cogent thinking and clear communication cannot be conducted like a race being run. Despite all the pressures to limit time in managed care and the pursuit of putative efficiency, doctors and patients should push back.

Finding the right answer often takes time. Haste makes cognitive errors.

Many doctors have consequently stopped charging medical aid tariffs, and do not consider themselves bound thereby. If a doctor were to submit his invoice to the patient's medical aid scheme for payment, he or she would not be paid directly, but the tariff amount would rather be paid into the patient (scheme member's) bank account. This then creates logistical and legal problems for the doctor in trying to recover the money from a (dishonest) patient who may not have the need consult the doctor again. Because of this, the patient may feel less obligated to tender payment for services rendered. This being said, the doctor also realizes that it would make no sense to litigate against such patients for relatively paltry amounts of money because the legal fees involved will significantly outweigh the debt.

Whereas the initial idea of medical aid societies was that they would enable their members to afford private medical care, after the advent of the Medical Schemes Act, which gave statutory recognition to the Representative Association of Medical Schemes, the medical aid movement, in the guise of protecting the

public, took it upon itself to interfere with both the contents as well as the level of tariffs, with what I have always believed to be a spurious claim, viz. that they were acting in the best interests of the patients!

(Le Roux, 2004)

Clinicians have consequently started to demand payment from the patient up front or, at the very least, upon conclusion of the consultation. The patient will then pay the clinician the full charge-out rate, submit a claim to their medical scheme, and will subsequently be reimbursed by the scheme, but only up to the scheme approved tariff amount. Indeed, as far afield as the United States of America, some physicians are converting to cash-only practices that refuse all forms of insurance (Hall, 2008).

3.5.3 Capping of annual escalations of Medical Aid

Tariffs below CPI:

Studies conducted by an independent health care consultancy, HealthMan⁶, indicate that the current National Health Reference Price List tariffs will have to

⁶ Health Man is a privately owned healthcare consultancy for the management and administration of specialist and healthcare networks.

increase by at least 170% for procedures and by 120% for specialist consulting codes to reflect the cost of running a private practice. For General Practitioners, a further increase of at least 25% will be required (Bateman, 2009). The results of these studies (of 1 296 specialist and GP practices) were presented to the Department of Health on 20 May 2008 and were 'consistent' with the South African Medical Association's submissions exactly a year earlier (ibid).

If we were to analyse the cost of consulting with private practitioners, most doctors need their own (expensive) equipment. We do not live in a society which dictates that independent practitioners (regardless of industry) need to pool their resources in order to curb collective costs. Partnerships, whether medical or in any other commercial environment, are fraught with financial pitfalls for those concerned, and a practitioner should be free to choose how he / she structures his / her practice. If this is indeed done on a solitary basis, then the need for one's own equipment is self-explanatory. Alternatively, many practices choose to lease their equipment for a set monthly cost. Such cost is generally very high, but the leases are generally designed to include any unforeseen

maintenance costs as well as replacement costs when newer / better equipment is launched.

It is submitted that it borders on false and misleading marketing practices for medical aidschemes to advertise that their particular scheme pays up to 300% of tariff for instance, where the actual cost of a procedure or consultation may in fact be 400 – 500% of the said tariff. In the patient's mind, he or she believes that if their scheme pays up to 300% of the tariff that there should logically be no shortfall, however such member does not realize how low the tariffs actually are actually structured. Medical aid tariffs should hence bear some semblance to the realistic charges that need to be levied by practitioners in order to generate a profit. This is simply a requirement of justice and equity.

In this chapter, I have illustrated at least the principal contentious issues that currently befall the relationship between medical scheme and member. In the following Chapter, I shall discuss the extent to which the Consumer Protection Act is likely to have a bearing on this relationship.

Chapter 4: The Consumer Protection Act

4.1 Introduction

The Consumer Protection Act became fully operational on 1 April 2011. The Act lays the foundation for an era of the consumer in South Africa by introducing a single, comprehensive legal framework for consumer protection. Notable features include the introduction of necessary consumer rights, a Consumer Court, a Consumer Commission to serve as an investigative body for consumer complaints, and a Consumer Tribunal to adjudicate upon alleged serious breaches of the Act by suppliers and service providers.

4.2 Purpose and policy of the Act

The purpose of the Consumer Protection Act is to provide a framework for greater consumer protection. Therefore, should it be found that the Consumer Protection Act offers a greater degree of consumer protection than any conflicting legislation (which will invariably be the case), including the Medical Schemes Act, then the relevant provisions of the Consumer Protection Act shall, in terms of sections 2 (8) – (10), take precedence.

The following serves as a brief exposé regarding how the Act impacts on the ethical and legal relationship between medical schemes and members.

The specific provisions relevant to the legal and ethical relationship between a medical scheme and its members are set out below:

3. (1) The purposes of this Act are to promote and advance the social and economic welfare of consumers in South Africa by—

...

(b) reducing and ameliorating any disadvantages experienced in accessing any supply of goods or services by consumers—

...

(iv) whose ability to read and comprehend any advertisement, agreement, mark, instruction, label, warning, notice or other visual representation is limited by reason of low literacy, vision impairment or limited fluency in the language in which the representation is produced, published or presented;

(c) promoting fair business practices;

(d) protecting consumers from—

*(i) unconscionable, unfair, unreasonable,
unjust or otherwise improper trade
practices; and*

*(ii) deceptive, misleading, unfair or
fraudulent conduct;*

*(e) improving consumer awareness and
information and encouraging responsible and
informed consumer choice and behaviour;*

*(g) providing for a consistent, accessible and
efficient system of consensual resolution of
disputes arising from consumer transactions;*

In this regard, when interpreting the Consumer Protection Act, one must take into account the legally recognised mechanisms for doing so:

“If a provision has two possible meanings, the *contra fiscum* rule applies (Estate Reynolds v CIR, 1937 AD 70). This means that the meaning that benefits the individual is accepted (SIR v Raubenheimer, 1969 4 SA 314 (A)). As Van Niekerk (1971: 145) rightly points out, “this is actually an application of

the rule *semper in dubiis benigniora praeferenda sunt* (in cases of doubt, the most beneficial interpretation should be adopted). Generally speaking, this principle is fully in accordance with the spirit and scope of the fundamental rights entrenched in the Bill of Rights.”(Botha, 1998: 70)

Accordingly, wherever possible, the Consumer Protection Act should be interpreted to the benefit or advantage of the consumer, or in this specific case, the medical aid member. This represents a modern example of a preference, in the case of interpretative ambiguity, for the collective good to prosper over a single (commercial) entity.

4.3 The Consumer’s Right to Choose

The Act re-enforces the Consumer’s right to freedom of choice, which right is also to be found in section 18 of the Constitution (Constitution of the Republic of South Africa, Act 108 of 1996). In the context of a member of a medical scheme, such member should not be prevented from consulting with medical professionals of his or her choice.

Prevention, in this sense, takes into account that if a scheme refuses to pay for or towards the costs of such

consultation, they are, in effect, preventing the member from consulting the practitioner concerned. In this regard, section 13 of the Act stipulates:

13. (1) A supplier must not require, as a condition of offering to supply or supplying any goods or services, or as a condition of entering into an agreement or transaction, that the consumer must—

(b) enter into an additional agreement or transaction with the same supplier or a designated third party; or

(c) agree to purchase any particular goods or services from a designated third party, unless the supplier—

(i) can show that the convenience to the consumer in having those goods or services bundled outweighs the limitation of the consumer's right to choice;

(ii) can show that the bundling of those goods or services results in economic benefit for consumers; or

(iii) offers bundled goods or services separately and at individual prices.

...

Frequently, Medical Aid companies offer schemes to the lower-income population bracket, in terms of which scheme members' medical consultations shall be paid for directly by the scheme on the express condition that the member consults with only those clinicians on a pre-selected list of preferred service providers as provided by the scheme. It would appear that such a scheme contravenes Section 13(1) on account that such practices cannot be justified by "the convenience to the consumer in having those ... services bundled outweighing the limitation of the consumer's right to choice, or the bundling of those ... services resulting in economic benefit for consumers" (section 13(1)(c)(iii) does not apply).

This type of scheme removes a significant portion of the patient's autonomy from the spectrum of patient rights in exchange for an arrangement in terms whereof the selected doctors charge the medical aid lower rates in exchange for more pairs of feet being herded through their doors. It could be submitted in this regard that autonomy can only be removed from a patient, especially a patient who for any reason cannot understand the significance and purport of such removal, in

circumstances of emergency, and then only to the extent that such emergency dictates.

It could be argued that this practice is furthermore “unconscionable”, in terms of the Act, on two bases, namely:

- i) The quality of medical practitioners differ according to experience and expertise. To deny a member the opportunity to consult with a clinician of sufficient skill, as may be required in a given circumstance seems entirely “unfair and unjust”; and
- ii) Particularly in a medical context, severe prejudice could be suffered by a member who may have to travel significant distances to consult with a scheme-approved clinician when a more expensive yet unapproved clinician may be geographically more convenient

4.4 The right to information in plain and understandable language

The phraseology of medical aid contracts contains numerous references to technical jargon and complicated language, rendering the contract difficult for the average reasonable person to sufficiently comprehend. In this regard, section 22 states:

22. *(1) The producer of a notice, document or visual representation that is required, in terms of this Act or any other law, to be produced, provided or displayed to a consumer must produce, provide or display that notice, document or visual representation—*

(b) in plain language, if no form has been prescribed for that notice, document or visual representation.

(2) For the purposes of this Act, a notice, document or visual representation is in plain language if it is reasonable to conclude that an ordinary consumer of the class of persons for whom the notice, document or visual representation is intended, with average literacy skills and minimal experience as a consumer of the relevant ... services, could be expected to

understand the content, significance and import of the notice, document or visual representation without undue effort, having regard to—

(a) the context, comprehensiveness and consistency of the notice, document or visual representation;

(b) the organisation, form and style of the notice, document or visual representation; and

(c) the vocabulary, usage and sentence structure of the notice, document or visual representation;

Having perused and considered the list of exclusions of the aforesaid five medical schemes, a solid argument can be made that such exclusions, and indeed the greater medical insurance contract as a whole, are frequently drafted in a manner that is not in plain language. The ordinary consumer / prospective member with average literacy skills and minimal experience as a consumer of the relevant services, cannot reasonably be expected to understand the content, significance and import of the documents in question.

In this regard, note should be taken of the organisation of the contents of the aforesaid documents, as well as the

vocabulary used therein. There appears to be too much in the way of either legal or medical jargon for the average member to comprehend.

Considering that most medical aid members contract with their various schemes through a broker / intermediary, such broker / intermediary should be in a position to answer all questions from the prospective member in respect of terminology that is not clearly understood. This means that the broker / intermediary will be making representations on behalf of the scheme to prospective members. These representations will vary in import and significance, and in respect of which the medical aid scheme / company or the subsidiary scheme has no control.

This represents a significant risk to the medical aid / scheme because the Consumer Tribunal, in taking into account the spirit and purport of the Act, will be likely to rule in favour of a complainant who contracted with such medical aid / scheme on the basis of, and in terms of certain representations made by their authorised agent or representative, which in this case, is the broker or intermediary.

In order to minimise this risk, it is advisable for medical aids to appoint several persons to the role of “Contract Interpretation Advisor”,whom prospective members can contact in advance of signing their medical aid contracts in order to clarify any areas of concern or confusion that may have arisen either by a diligent perusal of the documentation, or as a result of the consultation between the broker and the prospective member.

Reference to this “Contract Interpretation Advisor” would appear in the contractual documents, and should in addition be pointed out to the prospective member by the broker. In this way, the medical aid / scheme has acted pro-actively in attempting to prevent misunderstandings and misrepresentations, resulting in the prospective member making a more informed decision in respect of whether to subscribe to a particular medical scheme or not.

Brokers, are by their very nature, independent agents with their own priorities and agendas, but the proposed Contract Interpretation Advisor would work for the medical scheme and hence have a fiduciary duty to act in good faith, cognisant of the legal and ethical implications of his advice.

Finally, it would appear that the appointment of a “Contractual Interpretation Officer” would make the facilitation and implementation of the Consumer Protection Act more manageable for the medical aid companies, vesting themselves with greater control. As such, compliance with the Act would then be that much easier.

4.5 Disclosure of price of goods or services

Section 23 of the Act stipulates:

(3) ... a retailer must not display any goods for sale without displaying to the consumer a price in relation to those goods.

(6) a supplier must not require a consumer to pay a price for any goods or services—

(a) higher than the displayed price for those goods or services;

What is significant about section 23 in respect of the Medical aid schemes /industry is that a price (of monthly contributions towards a medical scheme) should always be clearly displayed, including on the internet website of

the scheme, and that if, per chance, two different pricing references to the same scheme are made, that prospective clients would only be charged the lesser of the said two prices.

4.6 Unconscionable conduct

Section 40 of the Act states that:

(2) ... it is unconscionable for a supplier knowingly to take advantage of the fact that a consumer was substantially unable to protect their own interests because of ... ignorance, inability to understand the language of an agreement, or any other similar factor.

It is submitted that section 40(2) provides added impetus and necessity for medical schemes to appoint “Contract Interpretation Advisors” as described above. Prospective and existing members should have the right to contact a suitably qualified scheme employee to timeously advise them of the correct contractual interpretation ascribed to certain problematic or complicated provisions. In this manner, the scheme could not be said to have taken advantage of any prospective or existing member on

account of such person's ignorance, inability to understand the language of an agreement, or any other similar factor on account that facilities were proactively made available to the member for the express purpose of clarifying any confusion / ambiguity.

4.7 The right to fair, just and reasonable terms and conditions

Section 48 stipulates that:

48. (1) A supplier must not—

(a) offer to supply, supply, or enter into an agreement to supply, any goods or services—

(i) at a price that is unfair, unreasonable or unjust; or

(ii) on terms that are unfair, unreasonable or unjust;

(b) market any goods or services, or negotiate, enter into or administer a transaction or an agreement for the supply of any goods or services, in a manner that is unfair, unreasonable or unjust; or

(c) require a consumer, or other person to

whom any goods or services are

supplied at the direction of the

consumer—

(i) to waive any rights;

(ii) assume any obligation; or

(iii) waive any liability of the supplier,

on terms that are unfair, unreasonable or

unjust, or impose any such terms as a

condition of entering into a transaction.

It remains to be seen, in relation to section 48(1), which person or entity shall be responsible for determining what conduct falls under the ambit of “unfair, unreasonable or unjust”. It is submitted that where a medical scheme excludes too many conditions or procedures, or alternatively excludes a broad category / genre of conditions or procedures with no exception made for grounds of justification, that such exclusions shall be held to be unfair, unreasonable and / or unjust. An example of the above is Discovery Health, Spectramed and Oxygen’s general exclusion of all cosmetic procedures. In this regard, there appears to be a clear focus on elective cosmetic procedures being excluded, however, where there is medical justification for the procedure in question,

it is submitted that to continue to exclude such a procedure would be profoundly unfair.

An example of medical justification could be where a psychiatrist has drafted a formal opinion stating that the patient / member presently suffers / is likely to suffer from clinical depression (and the associated sequelae thereof) as a result of having a double mastectomy which was in itself necessary on account of breast cancer. To deny the member the facility of paying for a breast reconstruction seems iniquitous and against public policy. Furthermore, in the absence of a breast reconstruction procedure, the scheme would of necessity have to pay for anti-depressant and other medication for an extended duration, which cost will, in the medium to long term, in fact amount to more than the cost of the breast reconstruction surgery.

Section 48(2) stipulates:

(2) Without limiting the generality of subsection (1), a transaction or agreement, a term or condition of a transaction or agreement, or a notice to which a term or condition is purportedly subject, is unfair, unreasonable or unjust if—

- (a) it is excessively one-sided in favour of
any person other than the consumer or
other person to whom goods or
services are to be supplied;
- (b) the terms of the transaction or
agreement are so adverse to the
consumer as to be inequitable;
- (c) the consumer relied upon a false,
misleading or deceptive representation,
as contemplated in section 41 or a
statement of opinion provided by or on
behalf of the supplier, to the detriment
of the consumer;

It remains to be seen, in relation to section 48(2), which person or entity shall be responsible for determining what conduct falls under the ambit of excessively one-sided, although it is submitted that where a person is a member of a particular scheme that is intended to be comprehensive in nature, a list of exclusions that is too onerous, or specific exclusions which bear no logical nexus to the fair, just and reasonable intention of the policy / scheme, will be deemed excessively one-sided.

4.8 Notice required for certain terms and conditions

Frequently, terms of medical aid contracts are drafted in a manner that is very onerous for the consumer (member).

To this extent, section 49 stipulates that:

49. (1) *Any notice to consumers or provision of a consumer agreement that purports to—*

(a) limit in any way the risk or liability of the supplier or any other person;

(b) constitute an assumption of risk or liability by the consumer;

(c) impose an obligation on the consumer to indemnify the supplier or any other person for any cause; or

(d) be an acknowledgement of any fact by the consumer, must be drawn to the attention of the consumer in a manner and form that satisfies the formal requirements of subsections (3) to (5).

The relevant lists of exclusions spell out the circumstances in which the scheme's liability is limited and where the member assumes a certain degree of financial risk. It can be argued that by doing so, the medical aids are drawing adequate attention to the

exclusions in plain language, and that they give the consumer / prospective member an adequate opportunity in the circumstances to receive and comprehend the provision or notice. However, although one can debate whether the language utilised in such lists of exclusions is indeed “plain”, it is doubtful that a scheme could reasonably believe that all of its members, at the time of subscribing to their policies, had a sufficient opportunity to examine and comprehend the length and breadth of the said exclusions.

It is submitted that there exists some scope in this regard to strengthen the wording of the contracts to include a provision stating: “The member has had sight of the list of exclusions in respect of which the scheme shall make a limited / no financial contribution. The member understands the import and consequences of such exclusions, which are hereby incorporated into and form part of this medical aid contract.”

The corollary of this is that the member has a responsibility to ask all relevant questions of the broker as to the import and consequences of the exclusions. This statement is premised on the assumption that the

author's suggestion of medical aid companies employing
"Contract Interpretation Advisors" is not taken up.

*(2) In addition to subsection (1), if a provision or notice
concerns any activity or facility that is subject to any
risk—*

(a) of an unusual character or nature;

*(b) the presence of which the consumer
could not reasonably be expected to be
aware or notice, or which an ordinarily
alert consumer could not reasonably be
expected to notice or contemplate in
the circumstances; or*

*(c) that could result in serious injury or
death, the supplier must specifically
draw the fact, nature and potential
effect of that risk to the attention of the
consumer in a manner and form that
satisfies the requirements of
subsections (3) to (5), and the
consumer must have assented to that
provision or notice by signing or
initialling the provision or otherwise
acting in a manner consistent with
acknowledgement of the notice,*

*awareness of the risk and acceptance
of the provision.*

*(3) A provision, condition or notice contemplated
in subsection (1) or (2) must be written in plain
language, as described in section 22.*

*(4) The fact, nature and effect of the provision or
notice contemplated in subsection (1) must be
drawn to the attention of the consumer—*

*(a) in a conspicuous manner and form that
is likely to attract the attention of an
ordinarily alert consumer, having
regard to the circumstances; and (b)
before the earlier of the time at which
the consumer—*

*(i) enters into the transaction or agreement,
begins to engage in the activity, or
enters or gains access to the facility; or
(ii) is required or expected to offer
consideration for the transaction or
agreement.*

*(5) The consumer must be given an
adequate opportunity in the
circumstances to receive and*

comprehend the provision or notice as contemplated in subsection (1).

A contractual exclusion could be seen as being of an unusual character or nature; or that the consumer could not reasonably be expected to be aware of or have contemplated such provision; or that could result in serious injury or death, where for instance, Spectramed and Fedhealth stipulate that any benefit not specifically stated in the scheme rules is excluded, which places an extremely onerous liability on the scheme member. This means that the member must know the specified inclusions and be able to make reference to them in any medical circumstance, due to their closed nature.

One can then ask the question why, under such circumstances, it would be necessary to have a list of exclusions if everything that is not expressly included is excluded by default.

The added stipulation that such provisions are to be brought to the attention of the member, reduced to writing and signed by the member

obliges the medical aids to concretise the terms and conditions of their policies on an annual basis, which terms could be updated annually if timeous notice to such effect is duly received by the member. In this regard, Dinnie opines:

In the context of disclaimer and indemnity clauses, the provisions of section 49 create various formal hurdles, including specific notice, to the successful reliance on disclaimer(s) and indemnities. Except in the case of clauses that purport to exclude liability or indemnify in respect of gross negligence, there is, however, no general prohibition on the use of such clauses (Dinnie 2009: 45).

4.9 Written consumer agreements

Section 50 stipulates:

50. ...

(2) If a consumer agreement between a supplier and a consumer is in writing, whether as required by this Act or voluntarily—

(a) it applies irrespective of whether or not the consumer signs the agreement; and

(b) the supplier must provide the consumer with a free copy, or free electronic access to a copy, of the terms and conditions of that agreement, which must—

(i) satisfy the requirements of section 22; and

(ii) set out an itemised break-down of the consumer's financial obligations under such agreement.

It appears that section 50(2)(a) may be diametrically opposed to the intention and purport of section 49(2), which in the context of medical aid contracts, requires terms which are of an unusual character or nature; or that the consumer may not reasonably be expected to be aware of or have contemplated; or that could result in serious injury or death, to be reduced to writing and signed by the member. It also seems as though this could be a loophole through which medical schemes can motivate for (excessively) onerous contracts to be validated, which seems contrary to the intention of the Act.

To reiterate the purpose of the Act, Section 3(1) (d) specifically makes mention of protecting consumers from—unconscionable, unfair, unreasonable, unjust or otherwise improper trade practices; and deceptive, misleading, unfair or fraudulent conduct. Based on this, it

is clear that the intention of the legislature is to protect the consumer, and it is thus submitted that section 49(2) should survive a challenge emanating from the wording of section 50(2)(a) on the basis of the greater certainty and consumer protection created by section 49(2).

It is further submitted that schemes that require their members to pay a nominal fee in order to gain access to their full terms and conditions are doing so in contravention of section 50(2)(b).

Chapter 5: Concluding Remarks

Commenting on the ethics related to medical insurance, Julian Le Grand (1991: 124-125) said that where people suffer ill health as a result of factors beyond their control

... they should not suffer losses as a consequence. In cases where health risks are not obviously identifiable, then everyone is in some sense at equal risk and, therefore, everyone should bear the expected value of the relevant loss.

In the context of the contents of this research report, it seems only fair to state that if someone has medical insurance, and suffers ill health (whether mental or physical) as a result of factors beyond their control, that such person should, as a general rule, be able to expect their medical insurance to cover the reasonable costs of any corrective treatment or procedure.

It is recommended that individuals take responsibility for their own health, and carry medical insurance to cover the costs of only unforeseen medical expenses. John Knowles, the erstwhile president of the Rockefeller

Foundation, once wrote that one man's freedom in health is another man's shackles in taxes and insurance premiums, and urged that the idea of a "right" to health should be replaced by the idea of an individual moral obligation to preserve one's own health (Knowles, 1977). In this regard, it is recommended that greater emphasis be placed on wellness and disease prevention, similar to the much publicized "Vitality" program initiated by Discovery.

It is understood that medical aid companies are commercially profitable entities, and are run, as any business should be, with the intention of maximizing profits and minimizing expenditure. It is also understandable that in order to maintain the requisite solvency ratio of 25%, the medical aid schemes must of necessity implement certain exclusions and / or restrictions to their payment protocols in order to ensure the commercial viability of the business. However, this report has illustrated and highlighted some instances of exclusions that are considered as contentious issues to be revisited by medical schemes. In doing so, they may be more in line with holistic ethical medical practice and all applicable recent legislation.

Finally, it is hoped that this research report serves to remind both the medical aid industry and the public at large that there are many facets to their convoluted relationship, and that this relationship requires meaningful input, feedback and participation from both parties.

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Human Research Ethics Committee (Medical)
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Ref: W-CJ-100604 -1

04/06/2010

TO WHOM IT MAY CONCERN:

Waiver: This certifies that the following research does not require clearance from the Human Research Ethics Committee (Medical).

Investigators: Mr Howard Snoyman (Student No 388096)

Project title: Ethical and legal considerations in the relationship between medical scheme and member.

Reason: This study is an analysis of literature in the public domain. There are no humans involved.



Professor Peter Cleaton-Jones
Chair: Human Research Ethics Committee (Medical)

copy: Anisa Keshav, Research Office, Senate House, Wits